Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS & SURGEONS
4780 NORTH JOSEY LANE
CARROLLTON TX 75010

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-12-2309-01

MFDR Date Received
MARCH 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Insurance denied stating operative report does not support services rendered but it does. Insurance denied stating Assitant can not be billed for this service but they can with supporting documentation."

Amount in Dispute: $1,730.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with provider's submitted codes & documentation, CMS surgical assistant payment status of codes, NCCI Edits, NCCI & CMS policy, the surgeon & assistant charges for DOS 7/28/11 have been correctly reimbursed.."

Response Submitted by: Claims Management, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2011	CPT Code 29875-LT-59	$592.75	$0.00
	CPT Code 29880-AS-LT	$663.14	$0.00
	CPT Code 29875-AS-59-LT	$474.20	$0.00
TOTAL		$1,730.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the

disputed service.

3. 28 Texas Administrative Code §134.600, effective May 2, 2006, 31 TexReg 3566, requires preauthorization for the disputed services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1-Workers compensation state fee schedule adjustment.
   - 299-This service is an integral part of total service performed and does not warrant separate procedure charge.
   - 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed.
   - B15-Payment adjusted because this procedure/service is not paid separately.
   - 5036-Complex Bill – Reviewed by Medical Cost Analysis Team.
   - 54-Multiplephysicians/Assistants are not covered in this case.
   - 98-Assistant surgeon services not warranted for this procedure.
   - 285-Please refer to the note above for a detailed explanation of the reduction.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct, therefore, no additional allowance appears to be warranted.
   - 5056-Preauthorization not obtained.
   - 197-Payment denied /reduced for absence of precertification/authorization.

Issues

1. Does a preauthorization issue exist in this dispute regarding the surgeons charges for CPT code 29875-LT-59?
2. Is CPT code 29875-LT-59 bundled in another service/procedure rendered on this date?
3. Were the assistant surgeon services warranted for CPT code 29880-AS-LT? Does the documentation support billed service?
4. Is CPT code 29875-AS-LT bundled in another service/procedure rendered on this date? Does the documentation support billed service?

Findings

1. CPT code 29875 is defined as “Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure).”

   According to the explanation of benefits, the respondent denied reimbursement for the surgeons charges for CPT code 29875-LT-59 based upon reason codes “B15, 97, 899 and 299.”

   On the disputed date of service, the requestor billed CPT codes 29880-LT, 29877-LT-59, 29884-LT-59 and 29875-LT-59. The respondent paid for the surgeons charges for code 29880-LT.

   Per NCCI edits, CPT code 29875 is a component of CPT code 29880; however, a modifier is allowed to differentiate the service.

   CPT code 29880 is defined as “Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.”

   A review of the requestor’s billing finds that the requestor appended modifier “59-Distinct Procedural Service” to CPT code 29875.

Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The requestor noted in the Operative report that "synovectomy and shaving chondroplasty performed of all 3 compartments." Because the synovectomy was performed in a different compartment of the knee reimbursement is not bundled in another service.

2. According to the explanation of benefits, the respondent also denied reimbursement for CPT code 29875-LT-59 based upon reason codes "5056 and 197."

   28 Texas Administrative Code §134.600 (p)(2) and (3) states "Non-emergency health care requiring preauthorization includes: (2) (outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section; and (3) spinal surgery."

   28 Texas Administrative Code §134.600 (a)(1) states "The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise: Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care."

   The respondent states in the position summary that "29875 not requested or approved for pre-auth."

   The requestor did not submit a copy of the preauthorization report to support that the disputed service was preauthorized. As a result, a preauthorization issue does exist in this dispute and reimbursement cannot be recommended.

3. CPT code 29880 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed."

   According to the explanation of benefits the respondent denied reimbursement based upon reason codes "54 and 98."

   A review of CMS Payment Policy indicator finds that CPT code 29880 has a payment policy indicator of "0" for Assist at Surgery.

   Per NCCI edits, an assist-at-surgery is allowed with documentation. The requestor did not submit documentation to support billed service. As a result, reimbursement cannot be recommended.

4. CPT code 29875 is defined as "Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)."

   According to the submitted explanation of benefits the insurance carrier denied additional reimbursement for CPT code 29875-AS-LT based upon reason code "97".

   As stated in number 1 above, in this dispute CPT code 29875 is not bundled in another service or procedure.

   A review of CMS Payment Policy indicator finds that CPT code 29875 has a payment policy indicator of "0" for Assist at Surgery.

   Per NCCI edits, an assist-at-surgery is allowed with documentation. The requestor did not submit documentation to support billed service. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not stablished that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/12/2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.